FORWARDHEALTH
PERSONAL CARE ADDENDUM

Instructions: Print or type clearly. Refer to the Personal Care Addendum Completion Instructions, F-11136A, for information on completing this form.

SECTION I — PROVIDER INFORMATION

1. Name — Provider	2. Provider Number

SECTION II — MEMBER INFORMATION

3. Name — Member	4. Member Identification Number

SECTION III — GENERAL ASSESSMENT

5. Skilled Visits Required by Member (Check all that apply.)

- ❑ Registered Nurse
- ❑ Licensed Practical Nurse
- ❑ Home Health Aide
- ❑ Physical Therapist
- ❑ Occupational Therapist
- ❑ Speech-Language Pathologist

6. Communication Capability (Check one.)

- ❑ Communicates needs verbally.
- ❑ Communicates verbally with difficulty, but can be understood.
- ❑ Communicates with sign language, symbol board, written messages, gestures, or interpreter.
- ❑ Communicates inappropriate content, makes garbled sounds.
- ❑ Does not communicate needs.
- ❑ Child with age-appropriate communication.

7. Hearing Aid Usage

Does the member wear a hearing aid? ❑ Yes ❑ No

If yes, what is the member's ability to hear with the hearing aid, if customarily worn? (Check one, if applicable.)

- ❑ No hearing impairment.
- ❑ Hearing difficulty at level of conversation.
- ❑ Hears and understands only very loud sounds (e.g., person speaking to member must yell to be heard.)
- ❑ No useful hearing; unable to interpret audible sounds.
- ❑ Not determined.

8. Vision Correction

Does the member wear corrective lenses? ❑ Yes ❑ No

If yes, what is the member's ability to see with corrective lenses, if customarily worn? (Check one, if applicable.)

- ❑ Has no impairment of vision.
- ❑ Has difficulty seeing at level of print, but may be able to read large or thick print.
- ❑ Has difficulty seeing obstacles in environment.
- ❑ Has no useful vision.
- ❑ Not determined.

Continued

SECTION III — GENERAL ASSESSMENT (Continued)

9. Orientation (Check one.)

❑ Oriented

❑ Minor forgetfulness of the following (Check all that apply.)

❑ Time ❑ Medications
❑ Place ❑ Meals
❑ Person

❑ Partial or intermittent periods of disorientation in the following (Check all that apply.)

❑ a.m. ❑ Consistently
❑ p.m. ❑ Inconsistently
❑ Two Hours or Less

❑ Totally disoriented — does not know time, place, or identity

❑ Comatose

❑ Not determined

10. Medications

Medication Name	Dosage / Frequency	Route	Start Date	End Date

11. Supporting Rationale for Requested Increase of Units

Continued

SECTION IV — SOCIAL INFORMATION

12. Social / Economic / Cultural Factors

13. Scheduled Activities Outside Residence

Does the member attend regularly scheduled activities outside his or her residence? ❑ Yes ❑ No

If yes, specify in the following table the times of day for each activity.

Scheduled Activity	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
School							
Work							
Day Program							
Other (Specify) ________________							
Other (Specify) ________________							

SECTION V — HISTORY OF CONDITION

14. Condition / Past and Present Problems Affecting Personal Care

SECTION VI — STAFFING SCHEDULE

15. Staffing Schedule of Each Agency or Provider Providing Services

Specify the times of day each provider provides services.

Level of Care	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Skilled Nursing Services							
Home Health Aide Services							
Personal Care Worker Services							
Case Sharing (Specify agency[ies]) ________________							
Other (Specify, e.g., Home and Community-Based Waiver Services Worker) ________________							

16. Other Information

SECTION VII — SIGNATURE

17. **SIGNATURE —** Authorized Nurse Completing Form	18. Date Signed